SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

TABLE OF CONTENTS

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

TABLE OF CONTENTS (cont.)

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.01 **DEFINITIONS**

Effective 09/29/02

96.01-1 "Private Duty Nursing(PDN) and Personal Care Services (PCS)" are those covered services provided to an eligible member, as defined in this Section, when determined to be medically necessary, when prior authorized, and in the best interest of the member according to the orders and written plan of care reviewed and signed by a licensed physician. Except as described in Section 96.03, all services provided are not to exceed the cost limits set forth in Section 96.03.

Effective 09/29/02

96.01-2 "Covered Services" are those services for which payment can be made under Title XIX or XXI by the Department of Human Services.

96.01-3 “Private Duty Nursing Services" are those services which are provided by a registered nurse and/or a licensed practical nurse, in accordance with the Board of Nursing Regulations, under the direction of the member's physician, to a member in his or her place of residence or outside the member's residence, when required life activities take the member outside his or her residence (school, preschool, daycare, medical appointments, etc.). Reimbursement for services provided outside a member's residence shall include nursing services and authorized IADLs only and shall not exceed that which would have been allowed strictly in a home setting. For purposes of this Section, "place of residence" does not include such institutional settings as nursing facilities, intermediate care facilities for persons with mental retardation (ICFs-MR), or hospitals. If nursing services are covered under a private non-medical institution’s per diem, then for Levels II, III, VI, VII, private duty nursing services are not allowed under this Section.

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

96.01-4 “Personal Care Services" are those Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) services provided in a member's residence by a home health aide, certified nursing assistant or a personal care assistant, as appropriate, while completing tasks in accordance with an authorized plan of care. For the purposes of this Section, place of residence does not include such institutional settings as nursing facilities, intermediate care facilities for persons with mental retardation, or hospitals. If personal care services are covered under a private non-medical institution’s per diem, then for Levels I, II, III, VI, VII, personal care services are not allowed under this Section.

Effective 09/29/02

96.01-5 A "Unit of Service" is a reimbursable unit of direct service as specified in Chapter III of this Section. A unit of service requires personal contact in or outside the member's place of residence made for the purpose of providing a covered service. When two or more persons provide separate and distinct types of services simultaneously, each must be recorded separately.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.01 **DEFINITIONS** (cont.)

Effective 09/29/02

96.01-6 "Average Monthly Cost" is one twelfth of the average annual cost as defined by the Department of Human Services. The costs of MaineCare physical therapy, occupational therapy, speech and hearing services and medical social worker services shall not be included in the calculation of this average monthly cost.

96.01-7 "Cueing" shall mean any spoken instruction or physical guidance which serves as a signal to do something. Cueing is typically used when caring for individuals who are cognitively impaired.

96.01-8 Limited Assistance is a term used to describe an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times, or

Effective 09/29/02

- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times plus weight-bearing support provided only one or two times.

96.01-9 One-person Physical Assist requires one person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last 7 days, or 24 to 48 hours if in a hospital setting. This does not include cueing.

96.01-10 Extensive Assistance means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three or more times, or

- Full staff performance during part (but not all) of the last 7 days.

Effective 09/29/02

96.01-11 Total Dependence means full staff performance of the activity during the entire previous 7 day period across all shifts, or during each 8 hour period in 24 hours.

Effective 09/29/02

96.01-12 Significant Change means a major change in the member's status that is not self limiting, impacts on more than one area of functional or health status,

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.01 **DEFINITIONS** (cont.)

and requires multi-disciplinary review or revision of the plan of care. A significant change assessment is appropriate if there is a consistent pattern of change with either two or more areas of improvement, or two or more areas of decline.

Effective 09/29/02

96.01-13 Assessing Services Agency (ASA). For all members age 21 and over, excluding those members classified for medication or venipuncture services under this Section, the ASA is authorized to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for covered services. Based upon a member's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of care, which shall specify all services to be provided under this Section, including the number of hours for services, and the provider types. The ASA is the Department's Authorized Agent for medical eligibility determinations, care plan development, and authorization of covered services under this Section.

Effective 09/29/02

Effective 09/29/02

96.01-14 Authorized Agent shall mean an organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement. The Assessing Services Agency (ASA) and the Home Care Coordinating Agency (HCCA) are Authorized Agents under this Section.

Effective 09/29/02

96.01-15 Home Care Coordinating Agency (HCCA). For all members age 21 and over, excluding those members classified for medication services or venipuncture services under this Section, the HCCA is responsible for a range of activities, which includes the following: coordinate and implement the services in the member's plan of care authorized by the ASA; ensure that authorized services are delivered according to the service authorizations; reduce, deny, or teminate services under this Section; serve as a resource to members and their families to identify available service options and service providers; answer questions; and assist with resolving problems. The HCCA is also responsible for administrative functions, including: maintaining member records; processing claims; overseeing and assuring compliance with policy requirements by any and all sub-contractors and conducting required utilization review activities.

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

96.01-16 Health Assessment shall be conducted by a PDN registered nurse for Level II and III members, and is a required component of the monthly nursing service under this Section unless otherwise specified in Section 96.04(B). The assessment shall be used for the management of chronic, stable conditions. The assessment must include the following components; physical vital signs, weight (if the member is confined to a bed so that a

96.01 **DEFINITIONS** (cont.)

weight measurement cannot be readily obtained by the nurse, this measurement may be postponed, observable weight changes should be noted), comprehensive systems review, nutritional status, medication review and compliance, health advice, environmental and social needs. The nurse shall communicate and follow-up with the physician and/or other providers as necessary. The health assessment must be forwarded to the HCCA for members age 21 and over. For members under age 21 the health assessment shall be maintained by the provider in the record. A health assessment is not a covered service for Level I members.

Effective 09/29/02

96.01-17 Contraindicated shall mean the member's condition renders some particular line of treatment improper or undesirable.

96.01-18 Medical Eligibility Determination (MED) Form shall mean the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are outlined in Section 96.02-4 and provide the basis for services and the care plan authorized by the ASA. The care plan summary contained in the MED form documents the authorized service plan. The care plan summary also identifies other services the member is receiving, in addition to the authorized services provided under this Section. For all members age 21 and over, excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to conduct the medical eligibility determination. For all members under age 21, and all those classified for medication services or venipuncture services under this Section, the PDN provider shall conduct the medical eligibility determination.

Effective 09/27/92

Effective 09/29/02

96.01-19 Authorized Plan of Care shall mean a plan of care which is authorized by the Assessing Services Agency, or the Department, which shall specify all services to be delivered to a member under this Section, including the number of hours for all covered services. The plan of care shall be based upon the member's assessment outcome scores recorded in the Department's medical eligibility determination form. For all members age 21 and over, excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to determine and authorize the plan of care. All authorized and covered services provided under this Section must be listed in the care plan summary on the MED form.

Effective 09/29/02

Effective 09/29/02

96.01-20 Activities of Daily Living (ADL): The only ADLs that will be considered for the purpose of determining eligibility are:

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.01 **DEFINITIONS** (cont.)

Effective 09/29/02

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
(iv) Eating: How person eats and drinks (regardless of skill);
(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
(vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
(vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

Effective 09/29/02

96.01-21 Instrumental Activities of Daily Living (IADL); For the purpose of determining eligibility, IADLs shall include only the following: preparing meals; light housework: washing dishes, dusting, making bed; routine housework: sweeping, vacuuming and washing floors, cleaning toilet, tub and sink, appliance care, changing linens, refuse removal; grocery shopping and storage of purchased groceries, and laundry either within the residence or at an outside laundry facility.

Effective 09/29/02

96.01-22 Unstable: A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every 8 hours is required. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included in this definition, is the loss of function resulting from a temporary disability from which full recovery is expected.

96.02 **ELIGIBILITY FOR CARE**

96.02-1 General and Specific Requirements

Effective 09/29/02

An individual is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements, the specific MaineCare eligibility requirements, and the medical eligibility requirements.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.02 **ELIGIBILITY FOR CARE** (cont.)

96.02-2 General MaineCare Eligibility Requirements

Effective 09/29/02

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

96.02-3 Specific Eligibility Requirements

Effective 09/29/02

A. Only individuals under age 21 are eligible for Level IV under this Section.

Effective 09/29/02

B. Individuals of any age are eligible for other levels of care.

Effective 09/29/02

96.02-4 Medical Eligibility Requirements

Applicants for services under this Section must meet the eligibility requirements as set forth in this Section and as documented on the Medical Eligibility Determination (MED) form. A member meets the medical eligibility requirements for a particular level of care if he or she requires a combination of assistance with the required numbers of Activities of Daily Living and nursing services, as appropriate. The requirements for each level of care are defined below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the Medical Eligibility Determination form.

Medical eligibility and the scores for criteria: (l) extensive assistance or total dependence, (m) behavior and (n) cognition, as well as, the Activities of Daily Living, shall be reviewed in the context of an individual's age-appropriate development. A child or infant shall not qualify for covered services by virtue of scoring high dependency requirements with the ADLs, or the aforementioned criteria, when these dependency requirements are normal for the child's age. The clinical judgment of the Department's Assessing Services Agency, or the PDN provider as required (for individuals under age 21), shall be determinative of the scores on the medical eligibility determination assessment.

Effective 09/29/02

Determination of Eligibility

A registered nurse trained in conducting assessments with the Department's approved MED form, shall conduct the medical eligibility assessment. In the process of completing the assessment the nurse assessor shall use professional nursing judgment. The assessor shall, as appropriate within the exercise of professional nursing judgment, consider documentation, perform

96.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 09/29/02

observations, and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physicians, and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment.

A. Level I

A member meets the medical eligibility requirements for Level I if he or she requires cueing seven (7) days per week for eating, toilet use, bathing, and dressing or requires limited assistance and a one person physical assist with at least two (2) ADLs.

B. Level II

Effective 09/29/02

A person meets the medical eligibility requirements for Level II, if he or she meets the criteria for requiring (B)(1) nursing services and assistance with (B)(2) activities of daily living as described below:

1. Nursing Services

Effective 09/29/02

To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below:

Effective 09/29/02

a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;

b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;

Effective 09/29/02

c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last thirty (30) days) or unstable condition;

d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis

96.02 **ELIGIBILITY FOR CARE** (cont.)

and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;

f. professional nursing assessment, observation and management of a medical condition;

g. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;

h. physical, speech/language, occupational, or respiratory therapy provided as part of a planned program that is designed, established, and provided by and requires the professional skills of a licensed or registered therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. Maintenance or preventative therapy does not meet the requirements of this Section. A continuous positive airway pressure (CPAP), or bilevel positive airway pressure (BIPAP) system or the wearing of an airway clearance system vest, does not meet the requirements of this Section;

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

i. services to manage a comatose condition;

j. care to manage conditions requiring a ventilator/respirator;

k. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);

Effective 09/29/02

l. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;

96.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 09/29/02

m. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;

Effective 09/29/02

n. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring; or

Effective 09/29/02

o. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

2. Activities of Daily Living:

Effective 09/29/02

An individual must require daily (7 days per week) "cueing" for all of the following ADLs: eating, toilet use, bathing, dressing; or, at least "limited assistance" and a "one person physical assist" is needed with at least any two activities of daily living.

C. Level III

A person meets the medical eligibility requirements for Level III if he or she requires at least “limited assistance” and a "one person physical assist" with two of the following ADLs: bed mobility, transfer, locomotion, eating, or toileting, and if he or she meets the criteria for nursing services below.

To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by, or under the supervision of, a registered professional nurse, as described below:

1. Nursing Services

a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention, other than daily insulin injections for an individual whose diabetes is under control;

b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within the last thirty (30) days) or unstable condition;

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 09/29/02

c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent, (within the last thirty (30) days) or unstable condition;

d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

e. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observations, for a new or recent (within last thirty (30) days) condition;

f. professional nursing assessment, observation and management of a medical condition;

g. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record;

h. physical, speech/language, occupational, or respiratory therapy provided as part of a planned program that is designed, established, provided by and requires the professional skills of a licensed or registered therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. Maintenance or preventative therapy does not meet the requirements of this Section. A continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BIPAP) system or the wearing of an airway clearance system vest, does not meet the requirements of this Section;

i. services to manage a comatose condition;

96.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 09/29/02

j. care to manage conditions requiring a ventilator/respirator;

k. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (e.g. grand mal);

l. professional nursing assessment, observation, and management for problems including wandering, or physical, or verbal abuse, or socially inappropriate behavior;

m. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;

n. administration of treatments, procedures, or dressing changes that involve prescription medications for post-operative or chronic conditions according to physician orders and require nursing care and monitoring; or

o. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

D. Level IV

Effective 09/29/02

An individual who is under 21 years of age is eligible for Level IV, if he or she meets the medical eligibility requirements set forth in Section 67.02-3, Nursing Facility Services, of the MaineCare Benefits Manual.

Effective 09/29/02

E. Level V

Effective 09/29/02

A person meets the medical eligibility requirements for Level V if he or she requires either (1) or (2) below.

1. Daily (7 days per week) nursing services and ventilator support for a ventilator-dependent person.

OR

2. a. Daily (7 days per week), twenty-four (24) hour nursing care for at least one of the following treatments and procedures: 96.02-4(B)(1)(a); (b); (c); (d); (i) or (k); required every eight (8) hours (or all three (3) shifts), which are, or otherwise would be, performed by an RN or LPN;

Effective 09/29/02

AND

96.02 **ELIGIBILITY FOR CARE** (cont.)

b. Daily (7 days per week) nursing care for at least any two (2) of the following professional nursing services: 96.02-4(B)(1)(a); (b); (c); (d); (i); or (k) .

Effective 09/29/02

F. Level VI Medication and Venipuncture Services for Severely Mentally Disabled Members.

Effective 09/29/02

An individual meets the medical eligibility requirements for Level VI if the following are met:

1. The individual meets the eligibility requirements for services under Section 17, Community Support Services for Persons with Severe and Disabling Mental Illness, and requires medication administration or monitoring services for the treatment of mental illness. The member's eligibility shall be established by a completed "verification of eligibility form" described in Section 17, or otherwise by a signed certification by a physician that the member is eligible/covered under Section 17. Dated copies of this form/certification must be maintained in the member's record to verify eligibility for covered services.

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

AND

Effective 09/29/02

2. A physician must sign and certify a statement that the member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a twenty (20) mile radius of the member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

G. Level VII Venipuncture Only Services

Effective 09/29/02

An individual meets the medical eligibility requirements for Level VII if the following are met:

1. The individual requires only venipuncture services on a regular basis, as ordered by a physician.

AND

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 09/29/02
Effective 09/29/02
Effective 09/29/02

2. A physician must sign and certify a statement that the member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a twenty (20) mile radius of the member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

96.03 **DURATION OF CARE**

Effective 09/29/02
Effective 09/29/02
Effective 09/29/02

Each Title XIX and XXI member may receive as many covered services as are medically necessary within the following limitations and exceptions as described below. MaineCare coverage of services under this Section requires prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care authorized by the ASA or the Department.

A. Exception to the Limit: For all individuals under the age of 21 years, the caps described below may be exceeded if services beyond these levels are determined medically necessary pursuant to the criteria described in Prevention, Health Promotion and Optional Treatment Services, formerly EPSDT, of the MaineCare Benefits Manual. A determination of medical necessity for PDN/PCS shall not be determinative of medical necessity under Prevention, Health Promotion and Optional Treatment Services. These additional services do not require prior authorization by the Department, however, there must be sufficient documentation related to all services and services may be subject to review and action by the Surveillance and Utilization Review Unit.

Effective 09/29/02

Limits (when applicable) for individuals under age 21 years shall be based upon a yearly cap to better serve children who have episodic service needs.

Effective 09/29/02
Effective 09/29/02

B. Except as described in (A) above, for individuals classified for Levels I, II, or III of care the total monthly cost of covered private duty nursing, and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the MaineCare Benefits Manual, may not exceed the monthly Level I, II, and III caps established by the Department and the plan of care authorized by the ASA on the MED form. Nursing services are not a covered service for members at Level I eligibility.

Effective 09/29/02

C. Except as described in (A) above, for individuals classified for Level IV of care, the total cost of private duty nursing and personal care services, either alone or in

96.03 **DURATION OF CARE** (cont.)

Effective 09/29/02 combination with home health services provided under Chapters II & III, Section 40 of theMaineCare Benefits Manual, may not exceed 100% of the Department's average annual cost of NF institutional services.

Effective 09/29/02 D. Except as described in (A) above, for all individuals who are determined medically eligible for Level V care, the total monthly cost of private duty nursing and personal care services, either alone or in combination with home health services provided Effective 09/29/02 under Chapters II & III, Section 40 of the MaineCare Benefits Manual, may not exceed the monthly Level V cap established by the Department. The Department reserves the right to request additional information to evaluate medical necessity.

E. Services under this Section may be denied, reduced or terminated by the Department, its Authorized Agent, or the PDN provider, as appropriate, for the following reasons:

Effective 09/29/02 1. A significant change occurs in the member's medical status such that an authorized plan of care under this Section can no longer be developed; or

Effective 09/29/02 2. The member becomes an inpatient of a hospital, nursing facility, ICF-MR; or

3. The member is not medically eligible to receive services under this Section or financially eligible to receive Title XIX or XXI benefits; or

Effective 09/29/02 4. Based upon the most recent MED assessment, the plan of care service authorization may be reduced to match the member's needs as identified in the reassessment and subject to the limitations of the program cap, as follows:

Effective 09/29/02 a. for members age 21 and over, excluding those classified for medication services or venipuncture services under this Section according to the clinical judgment of the Department, the ASA or HCCA;

Effective 09/29/02 b. for members under age 21, as well as those classified for medication services or venipuncture services under this Section, by the Department or the PDN provider; or

Effective 09/29/02 5. The member declines services; or

6. The member refuses personal care or nursing services; or

7. The health or safety of individuals providing services is endangered.

Effective 09/29/02 F. Suspension. Services may be suspended for up to thirty (30) days while the member is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the member's service coverage will be terminated and the member will need to be reassessed to determine medical eligibility for these services.

Effective 09/29/02 Services may also be suspended for a member who requires Section 40, Home Health Services. Home health services and services under this Section must not duplicate one another.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.04 **COVERED SERVICES**

Effective 09/29/02 Covered services are available for individuals meeting the eligibility requirements set forth in Section 96.02. Covered services must be required in order to maintain the member's current health status, or prevent or delay deterioration of a member and/or delay long-term institutional care. These services require prior authorization by the Department, or its Assessing Services Agency and are subject to the limits in Section 96.03.

Effective 09/29/02 Services provided must be reasonable and necessary for meeting the medical needs of the individual, based upon the medical record, and upon the outcome scores on the MED form, and as authorized in the plan of care. Coverage will be denied if the services provided are not consistent with the member's authorized plan of care. The Department may also recoup payment for inappropriate service provision, as determined through post payment review.

Effective 09/29/02 For members age 21 and over, excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

Effective 09/29/02 For members under age 21 at any level of service, as well as Level VI and Level VII members, the PDN provider shall establish a plan of care. The plan of care shall be based upon the member's assessment outcome scores recorded in the Department's Medical Eligibility Determination (MED) form and the timeframes therein.

Effective 09/29/02 Section 40, Home Health Services, shall not replace or be delivered and reimbursed in lieu of authorized Section 96 covered services. (Section 40, Home Health Services, must be delivered and reimbursed pursuant to those rules.) Covered services under this Section include the following:

A. Private Duty Nursing Services must be provided according to a written plan of care, reviewed and signed by a licensed physician, and available to the Department or the HCCA upon request.

Effective 09/29/02 For individuals age 21 and over, excluding those classified for medication services or venipuncture services under this Section, private duty nursing services shall be authorized by the Assessing Services Agency, and ordered, monitored and reimbursed by the HCCA, in accordance with the authorized plan of care for covered services under this Section.

Effective 09/29/02 For individuals under age 21, as well as all individuals classified for venipuncture services or medication services for the severely mentally disabled, the Department shall classify the member based on the plan of care developed by the provider, subject to the process described under Section 96.06.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.04 **COVERED SERVICES** (cont.)

Nursing services may be provided by:

1. an independently practicing registered professional nurse;

2. a registered professional nurse or licensed practical nurse employed by, or under contract with, a licensed home health agency.

Effective 09/29/02

Nursing services shall not be covered when provided by the member's husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.

Effective 09/29/02

B. Monthly Nursing Service for Levels II and III. Once each month, comprehensive nursing services shall be provided to each Level II and III member. This service shall include a health assessment, as well as any other nursing services that are required/authorized in the plan of care. If the member requires any additional nursing services during the month, those services will be reimbursed as registered nursing services. The monthly health assessment may be billed no more than once per month. The frequency of the monthly health assessment may be reduced to once per quarter if recommended by the RN conducting the health assessment and determined appropriate following review with the HCCA and other appropriate persons involved in implementing the plan of care. This does not eliminate the need for the member to receive a monthly registered nursing service. For those receiving home and community benefits for members with mental retardation as allowed in 96.05(L), the need for a monthly health assessment is determined by the clinical judgment of the RN assessor determining eligibility.

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

Effective 09/29/02

C. Personal Care Services (PCS). For members under the age of 21, PCS must be ordered by a physician and delivered under a plan of care prepared by the PDN provider and signed by the physician.

Effective 09/29/02

For members age 21 and over, PCS must be authorized by the Department, or its Assessing Services Agency, and specified in the authorized plan of care.

As a general rule, there shall be no more than one (1) personal care staff member delivering services at a time. If the Department, or its ASA, (or the physician for individuals under age 21) determines that an individual, based upon his/her health status, requires more than one personal care staff member to perform a specific ADL task (e.g. to transfer a large person), then this can be authorized and specified in the plan of care.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.04 **COVERED SERVICES** (cont.)

Effective 09/29/02 Personal care services include services related to a member's physical requirements for assistance with the activities of daily living, including assistance with related health maintenance activities.

Effective 09/29/02 Additionally, when authorized and specified in the Department, or ASA authorized plan of care, PCS may include IADL and related health maintenance tasks, which are directly related to the member's plan of care. These tasks must be performed in conjunction with direct care to the member. These IADL tasks would otherwise be normally performed by the member if he or she were physically or cognitively able to do so. It must also be established that there is no family member or other person available to assist with these tasks. A child or infant shall not qualify for coverage of IADL tasks because an infant or child does not normally perform these tasks. Coverage of IADL tasks is provided to assist individuals with disabilities to live independently in the community. IADL tasks may constitute up to, but shall not exceed, two-thirds of the total weekly time authorized for personal care services. At least one-third of the total weekly time authorized for personal care assistance shall be for ADL assistance. These tasks, and the allotted hours, must be specified and authorized in the plan of care.

Effective 09/29/02 Certified nursing assistants, home health aides, or personal care assistants may transport a member only to carry out necessary covered services in the member's plan of care. Escort services may be provided only when a member is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service.

Effective 09/29/02 Such documentation must be included in the member's record. Coverage is not available to reimburse for mileage or vehicle usage under this Section. Only the provider's services are covered.

Effective 09/29/02 Personal care services shall be provided, as appropriate, by a:Effective

1. Home health aide;
2. Certified nursing assistant; or
3. Personal care assistant.

Effective 09/29/02 Personal care services shall not be covered when delivered by a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

Effective 09/29/02 The task time allowances set forth in Appendix 1 must be used to authorize the time covered to complete covered and authorized ADL and IADL tasks for the plan of care. For members age 21 and over, the Authorized Agent shall abide by Appendix 1. For members under age 21, the PDN provider shall abide by

96.04 **COVERED SERVICES** (cont.)

Effective 09/29/02
Appendix 1. These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Agent and the PDN provider will use these allowances when authorizing a member's care plan. If these times are not sufficient when considered in light of a member's extraordinary circumstances as identified and documented by the Authorized Agent or the PDN Provider, the Authorized Agent or the PDN Provider may make an appropriate adjustment.

D. Venipuncture Services. Venipuncture shall be covered when it is the only identified nursing need and is required on a regular basis, as ordered by the physician. An Effective 09/29/02 RN or LPN must deliver venipuncture services. PCS are not covered services under venipuncture services. If the member requires additional services, then he/she must meet (at least) the eligibility requirements for Level II or III. If the member qualifies for Level II or III then all services including venipuncture services shall be authorized and delivered under Level II or III.

E. Medication and Venipuncture Services. Medication services are those services which are directly related to the administration and/or monitoring of medications intended for the treatment and management of mental illness in the context of Effective 09/29/02 community support services for people with severe and disabling mental illness. Monitoring services may include venipuncture services for members under this Effective 09/29/02 Section. A psychiatric nurse or a registered professional nurse must deliver these services. PCS are not covered services under this Section 96.04(E). If the member requires additional services, then he/she must meet (at least) the eligibility requirements for the level II of care. If the member qualifies for Level II or III then all services including medication services shall be authorized and delivered under the Level II or III.

F. Interpreter Services. Interpreter services for the hearing impaired and for foreign languages are available as described in Chapter I.

96.05 **NON-COVERED SERVICES**

The following services are not reimbursable under this Section:

Effective 09/29/02 A. Services for which the cost exceeds the limits described in this Section, except as described in 96.03(A);

Effective 09/29/02 B. Psychiatric nursing services, except as described under 96.04;

Effective 09/29/02 C. Those services which can be reasonably obtained by the member outside his/her place of residence;

Effective 09/29/02 D. Nursing services when provided by the member's husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister,

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.05 **NON-COVERED SERVICES**

father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit;

Effective 09/29/02 E. Personal care services provided by a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative;

Effective 09/29/02 F. Homemaker and chore services not directly related to medical necessity. Homemaker and chore services are covered in this Section only as authorized by the ASA in the plan of care when required;

G. Services in an ICF-MR, nursing facility or hospital;

Effective 09/29/02 H. Services to members receiving any Home and Community Benefits for the Elderly, or Adults with Disabilities (nursing and personal care services are covered under these waiver benefits).

Effective 09/29/02 I. Escorting members outside of the home, except as described in Section 96.01-3 or 96.04(C);

J. Custodial care or respite care;

Effective 09/29/02 K. Personal care services delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility which is reimbursed for providing personal care services. It is the responsibility of the AFCH or assisted living provider to deliver personal care services;

Effective 09/29/02

Effective 09/29/02 L. Personal care services (PCS) may not be provided to members receiving Home and Community Benefits for Persons with Mental Retardation or Home and Community Benefits for the Physically Disabled. PCS is a covered service under these Waivers. These members may receive nursing services only under this Section.

Effective 09/29/02 M. Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants or personal care assistants;

Effective 09/29/02 N. Services which are not authorized by the plan of care; and

Effective 09/29/02 O. Nursing services are not a covered service for members at Level I eligibility.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 POLICIES AND PROCEDURES

96.06-1 Eligibility Determination

Effective 09/29/02

Applicants for services under this Section must meet the eligibility requirements set forth in Section 96.02. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department, the ASA, or the PDN provider, as applicable.

Effective 09/29/02

Eligibility for individuals under the age of 21, and for Medication Services or Venipuncture Services shall be determined by the PDN provider, in accordance with the requirements of Section 96.02 and the MED form. These services require prior classification by the Department. All other PDN/PCS services, for members age 21 and over, require eligibility determination and prior authorization by the ASA.

Effective 09/29/02

Applicants ages 18 and over who meet the NF medical eligibility criteria also qualify for Home and Community Benefits. These benefits may provide a greater array and quantity of services than otherwise available under this Section 96; therefore, applicants must be assessed to determine whether they qualify for NF level of care. Members are prohibited from receiving Home and Community Benefits and services under this Section simultaneously, except as described in Section 96.05(L).

Effective 09/29/02

A. If financial eligibility for MaineCare has not been determined, the applicant, family member or guardian must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process.

B. The Department, or its ASA, shall conduct a medical eligibility assessment using the Department's approved MED assessment form. The individual conducting the assessment shall be a registered nurse (RN) and will be trained in conducting assessments and developing an authorized plan of care with the Department's approved tool. The RN assessor's findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the authorized plan of care.

Effective 09/29/02

C. The PDN provider shall develop a nursing plan of care, which shall be reviewed and signed by the member's physician. It shall include the personal care and nursing services authorized by the ASA or the Department, and the nursing plan signed by the member's physician.

Effective 09/29/02

D. The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 96.03.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02
E. An individual's specific needs for medical services must be reviewed and approved by the member's physician at least every sixty-two (62) days, and so documented in the medical record and nursing plan of care by the RN;

Effective 09/29/02
1. Members age 21 and over. Applicants, age 21 and over, who meet the eligibility criteria for PDN services, as set forth in Section 96.02, and as documented by the Department's approved MED assessment form, shall:

Effective 09/29/02
a. Be assigned, by the ASA, to the appropriate level of care, and receive an authorized plan of care based upon the scores, timeframes, findings and covered services recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of care shall: 1) not exceed the established financial caps; 2) be prior authorized by the Department or its ASA; and 3) be under the direction of the member's physician for the nursing plan of care.

Effective 09/29/02
b. The assessor shall approve a classification period for the member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. A classification period shall not exceed twelve (12) months.

c. The assessor shall forward the completed assessment packet to the Department's authorized Home Care Coordinating Agency (HCCA) within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care.

Effective 09/29/02
d. The HCCA shall contact the member within twenty-four (24) hours of receipt of the MED assessment and authorized plan of care. The HCCA shall assist the consumer with locating providers and obtaining authorized services. The HCCA shall implement and coordinate services with the provider agency or independent contractor using service authorizations, as well as, monitor service utilization and assure compliance with this policy. In the event a member experiences an emergency or an acute episode, the HCCA has the authority to adjust the frequency of services under the authorized care plan, up to 15%, as long as the total

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02

authorized care plan hours are not exceeded, in order to meet the member's needs. A significant or long-term change requires a reassessment by the ASA.

e. The provider or independent contractor shall request authorization from the Department's Authorized Agent for any change in the authorized plan of care. The Authorized Agent shall be responsible to assure that the authorized plan of care shall not exceed the financial "cap" established by the Department.

Effective 09/29/02

f. Complete standardized referral requests for Level V services for individuals age 21 and over must be submitted to the Department or the ASA.

Effective 09/29/02

2. Members under age 21.

a. Services for individuals under age 21 require prior classification by the Department. The Department shall approve a classification period, not to exceed one (1) year.

Effective 09/29/02

b. An individual under age 21, who does not meet the eligibility criteria for PDN services as set forth in Section 96.02, may be reviewed under Prevention, Health Promotion, and Optional Treatment Services. If the provider determines that services are medically necessary pursuant to the criteria of Prevention, Health Promotion, and Optional Treatment Services, then services shall be provided in accordance with a plan of care and billed under this Section.

c. If a provider determines that any of the requested services, for an individual under age 21, are medically necessary, but are not available from that provider, the provider shall notify the family in writing (in the Department's approved notice format) which services are not available from that provider.

Effective 09/29/02

A copy of the letter shall be sent to the Department's Prevention, Health Promotion, and Optional Treatment Services staff, and Prevention, Health Promotion, and Optional Treatment Services staff shall offer to assist the member in locating other providers.

d. If the provider determines that the PDN/PCS services are not medically necessary, then the provider shall notify (using a notice format approved by the Department) the family in

96.06 **POLICIES AND PROCEDURES** (cont.)

writing of which services will be provided and which services will not be provided, or provided only on a reduced basis. The notice shall contain an understandable explanation of the reasons and inform them of their appeal rights and of Prevention, Health Promotion, and Optional Treatment Services. A copy of any denial/reduction notice shall be sent to the Prevention, Health Promotion, and Optional Treatment Services. Prevention, Health Promotion, and Optional Treatment Services will then offer to assist the family to see what other services may be provided to meet the child's needs.

Effective 09/29/02

e. The private duty nursing services provider shall develop a nursing plan of care and an authorized plan of care.

f. The anticipated costs of services to be provided under the plan of care must conform to the limits set forth in Section 96.03. The costs of physical therapy, occupational therapy, speech and hearing services shall not be included in the calculation of either the average annual cost of institutional services or the cost of PDN services required by the individual.

g. The PDN/PCS provider shall obtain the signature of the physician on the plan of care or a physician's order for private duty nursing and personal care services and for the medical treatment plan. This shall be made available to the Department or its Authorized Agent upon request. Services must also be authorized by the Department or its Authorized Agent.

Effective 09/29/02

h. For services to individuals under age 21, as well as individuals classified for venipuncture services and medication services, the eligibility assessment form and the plan of care shall be maintained in the member's medical record, available upon request for review by the Department. The provider must submit a copy of the medical eligibility determination form to the Department.

Effective 09/29/02

Effective 09/29/02

i. The provider shall be responsible for assuring that the plan of care shall not exceed the financial "cap" established by the Department.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

96.06-2 Reclassification and Continued Services

Effective 09/29/02

A. For all members under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of 5 days prior to and no later than the reclassification date.

Effective 09/29/02

For members under the age of 21, as well as members classified for venipuncture services and medication services, the MED assessment tool shall be submitted to the Bureau of Medical Services, Quality Improvement Division within seventy-two (72) hours of completion of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also know as the classification end date.

B. An individual's specific needs for medical services are reviewed at least every sixty-two (62) days, and so documented in the medical record and nursing plan of care by the RN;

96.06-3 Discharge Notification

Effective 09/29/02

A. A provider serving children under age 21, and members receiving venipuncture services and medication services, must notify the Department within forty-eight (48) hours of discharging a member from care.

Effective 09/29/02

B. A provider serving members age 21 and over must notify the HCCA within forty-eight (48) hours of discharging a member from care.

96.06-4 Professional and Other Qualified Staff

Effective 09/29/02

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by qualified professional staff licensure. Services provided by the following staff are reimbursable under this Section.

A. Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide Private Duty Nursing Services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

Effective 09/29/02

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

B. Psychiatric Registered Nurse

A registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.

C. Licensed Practical Nurse

A licensed practical nurse employed directly by or through a contractual relationship with a licensed home health agency may provide Private Duty Nursing Services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed provided they are supervised by a registered professional nurse.

D. Home Health Aide

Any home health aide employed directly by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed a training program for certified nurse assistants consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have satisfactorily completed an agency orientation as defined by the Regulations governing the Licensing and Functioning of Home Health Care Services and be listed on the CNA registry.

E. Certified Nursing Assistant (CNA)

A CNA employed by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed a training program for certified nurse assistants consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed on the CNA registry.

F. Personal Care Assistant (PCA)

Effective 09/29/02

A PCA must be employed by, or acting under a contractual relationship with a licensed home health agency or a registered personal care agency.

Effective 09/29/02

To be reimbursed, PCAs must meet either the training requirements or competency determination requirements described below. PCAs,

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02

newly employed and providing services after July 1, 2002 must complete the training and examination requirements within six (6) months of employment. A PCA must:

1. Currently be listed on the Certified Nursing Assistant's Registry, or A CNA whose registry status has lapsed due to inadequate employment in a health care institution may choose to take the competency-based examination of didactic and demonstrated skills from any BEAS approved curriculum. Successfully passing this examination will result in the award of certificate of training as a Personal Care Assistant.

   If the competency-based examination is not completed successfully, the CNA must:

Effective 09/29/02

   a. complete the training requirements outlined in Section C (3) of the BEAS Manual;
   b. provide evidence of satisfactory completion of a basic nurse's aide or home health aide training program meeting the standards of the Maine State Board of Nursing within the past three (3) years; or
   c. Applicants who have completed a basic nurse's aide course or home health aide training program more than three years ago may choose to take the competency-based examination of didactic and demonstrated skills from any BEAS approved curriculum. Successfully passing this examination will result in the award of a certificate of training as a personal care assistant.

2. The PCA training shall complete a training program, which meets the following conditions:

   a. The course must include at least forty (40) hours of formal classroom instruction, demonstration, return demonstration, and examination and must cover the tasks included in this Section.
   b. The course shall be designed and planned and coordinated by a registered nurse in collaboration with other healthcare professionals.
   c. The candidate must provide evidence of successfully passing a competency-based examination of didactic and demonstrated skills resulting in a certificate of training as a personal care assistant.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02

3. Prior to the start of delivering services in the member's home, the employing agency must provide the newly hired PCA with an eight (8) hour orientation that reviews the role and responsibilities of a PCA. The PCA must demonstrate competency in all required tasks prior to being assigned to a member's home. Demonstration of competency must be documented in the personnel records of the PCA and include the scope of the demonstration and the signature of the individual certifying competency.

   When the nature of the tasks or the condition of the member warrant specialized knowledge and skills, as determined by the medical eligibility assessment, the PCA shall be trained by the health professional and satisfactorily demonstrate the skill to carry out the necessary tasks.

Effective 09/29/02

4. Employment or Provider agency responsibilities include, but are not limited to the following:

Effective 09/29/02

   a. Providers employing personal care assistants (PCAs) must assure that all PCAs meet the training and competency requirements in this Section. The responsibility for verification of PCA credentials rests with the employer.

Effective 09/29/02

      i. Family and household members who are reimbursed for PCA services must comply with the training and competency rules.
      ii. Evidence of orientation, the certificate of training, and/or verification of competency shall be maintained in the PCA's personnel file.

Effective 09/29/02

   b. Providers employing CNAs or home health aides working as personal care assistants must assure that the CNA or HHA does not have a notation on the registry of certified nursing assistants for:

      i. Any criminal convictions, except for Class D and Class E convictions over 10 years old that did not involve as a victim of the act a patient, client, or resident of a health care entity; or

      ii. any specific documented findings by the State Survey Agency of abuse, neglect, or misappropriation of property of a resident, client, or patient.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02

c. Providers must develop and implement personnel policies that insure a smoke free environment. PCAs are not allowed to smoke, use alcohol, or controlled substances in the member's home or vehicle during work hours.

d. Supervisory visits shall be made to a member's home prior to the start of PCA services to develop and review with the consumer the plan of care as authorized by the Assessing Services Agency on the care plan summary and by the Home Care Coordinating Agency on the service order.

e. PCAs employed by agencies must receive on-site supervision of the implementation of the Level III and Level V member's authorized plan of care by their employer at least quarterly to verify competency and member satisfaction with the PCA performance in meeting the care plan tasks. For Level I and Level II members, on-site supervision may be every six (6) months with quarterly phone calls to the member. Ongoing direct on-site supervision of the PCA is up to the discretion of the provider agency as governed by its personnel policies and procedures.

f. Each personal care assistant's personnel record must include:

   i. which of the criteria in this Section, if applicable, were met for certifying the PCA;
   ii. documentation of PCA entrance and exit times and total time spent in the home; and
   iii. the name and telephone number of the person to call in case of an emergency or for advice or other needed information.

g. An agency may employ a family member of the MaineCare member to be a PCA, except for: the spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative. Coverage and reimbursement for services provided by any of these legally responsible relatives is prohibited.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Effective 09/29/02 96.06-5 Member's Records

A. Authorized Agent or Provider Records

Effective 09/29/02 There shall be a specific record for each member which shall include the following:

Effective 09/29/02 1. Member's name, address, phone number, emergency contact and date of birth; and

Effective 09/29/02 2. The member's medical eligibility determination form, release of information, authorized plan of care and copies of the eligibility determination notice and service authorizations issued by the Effective 09/29/02 Home Care Coordinating Agency for members over age 21.

B. Authorized Plan of Care

Effective 09/29/02 1. The authorized plan of care must indicate the type of services to be provided to the member, specifying who will perform the service, the number of hours per week, specifying the begin and end dates, and specifying the tasks and reasons for the service.

Effective 09/29/02 For all members age 21 and over, excluding those classified for medication services or venipuncture services under this Section, the Assessing Services Agency (ASA) has the authority to determine and authorize the plan of care.

Effective 09/29/02 2. Members may receive Medicare covered services, as applicable, during the same time period they receive MaineCare covered PDN/PCS. The authorized plan of care must identify the types Effective and service delivery levels of all other home care services to be 09/29/02 provided to the member whether or not the services are reimbursable by MaineCare. These additional home care services might be provided by such individuals as homemakers, personal care attendants and companions. These additional services shall include, but not be limited to, case management, home-delivered meals, physical therapy, speech therapy, occupational therapy, MSW services and hospice.

C. Nursing Treatment Plan of Care

The licensed home health agency provider or independent contractor shall obtain the signature of the physician on the nursing plan of care or a physician's order for nursing treatments and procedures, medications,

96.06 **POLICIES AND PROCEDURES** (cont.)

medical treatment plan and frequency and level of personal care services. This shall be made available to the Department or its Authorized Agent upon request. Covered services must be authorized by the Department or the ASA. Content of the nursing treatment plan must include the following information:

1. All pertinent diagnoses, including mental status;

2. All services, supplies, and equipment ordered;

Effective 09/29/02

3. The level of care, frequency and number of hours to be provided;

4. Prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any additional items the PDN services provider or physician choose to include. Orders for care must indicate a specific range in the frequency and number of hours. Orders may not be open-ended or "as needed;"

Effective 09/29/02

5. The nursing or treatment plan of care must be reviewed and signed by the member's physician as required by the Department in this Section.

D. Written Progress Notes

Written progress notes shall contain:

Effective 9/28/02

1. The service provided, date, and by whom;

Effective 09/29/02

2. Entrance and exit times of nurse's, home health aide's, certified nursing assistant's and personal care assistant's visits and total hours spent in the home for each visit. Exclude travel time [unless provided as a service as described in this Section];

Effective 09/29/02

3. a written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;

Effective 09/29/02

4. Progress toward the achievement of long and short range goals. Include explanation when goals are not achieved as expected;

Effective 09/29/02

5. Signature of the service provider; and

Effective 09/29/02

6. Full account of any unusual condition or unexpected event, dated and documented.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

All entries shall be signed by the individual who performed the service. Authorized and valid electronic signatures are acceptable.

E. Access to Records

Effective 09/29/02

Member records and any other files pertaining to services provided through this policy and reimbursed by MaineCare shall be available, without additional charge, for review by the Surveillance and Utilization Review Unit.

96.06-6 Surveillance and Utilization Review

All providers are subject to the Department's Surveillance and Utilization Review activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

Effective 09/29/02

96.06-7 Member Appeals

Effective 09/29/02

A member has the right to appeal in writing or verbally any decision made by the Department or its Authorized Agent, to reduce, deny or terminate services provided under this program. In order for services to continue during the appeal process, a request must be received by the Department within ten (10) days of the notice to reduce or terminate services. Otherwise, an individual has sixty (60) days in which to appeal a decision. Members shall be informed of their right to request an Administrative Hearing in accordance with this Section and Chapter I of this manual.

Effective 09/29/02

A. An appeal for members, aged 21 and over, must be requested in writing or verbally to:

Director
Bureau of Elder and Adult Services
c/o Hearings
Effective 11 State House Station
09/29/02 Augusta, ME 04333-0011

Effective 09/29/02

B. For members under the age of 21, and for all members classified for medication services or venipuncture services an appeal must be made by the member or his or her representative, in writing or verbally, for a hearing to:

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.06 **POLICIES AND PROCEDURES** (cont.)

Director
Bureau of Medical Services
Department of Human Services
11 State House Station
Augusta, Maine 04333-0011

For the purposes of determining when a hearing was requested, the date of the fair hearing request shall be the date on which the Director receives the request for a hearing. The date a verbal request for a fair hearing is made is considered the date of the request for the hearing.

Effective 09/29/02 The Bureau of Medical Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received.

96.07 **REIMBURSEMENT**

96.07-1 Reimbursement for Private Duty Nursing and Personal Care Services.

Effective 09/29/02 Reimbursement will be made on the basis of a partial hour rate as specified in Chapter III of this Section and shall be the lower of:

Effective 09/29/02 A. The amount listed in Chapter III, Section 96, Allowances for Private Duty Nursing and Personal Care Services, or

Effective 09/29/02 B. The provider's usual and customary charge.

Effective 09/29/02 In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other sources that

Effective 09/29/02 are available for payment of the rendered service prior to billing the MaineCare Program.

96.07-2 Licensed Home Health Care Agencies

In order to qualify for reimbursement under this Section as a Home Health Care Agency, the Home Health Agency must have in effect a license pursuant to the Department's Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.07 **REIMBURSEMENT** (cont.)

96.07-3 Registered Personal Care Agency

In order to qualify for reimbursement under this Section as a Personal Care Agency, the Agency must have in effect a registration pursuant to the Department's Rules and Regulations Governing In-Home Personal Care and Support Workers, as are currently in effect.

96.08 **COPAYMENT**

96.08-1 Copayment Amount

Effective 09/29/02

A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

Effective 09/29/02

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

Effective 09/29/02

B. The member shall be responsible for copayments up to $5.00 per month whether the copayment has been paid or not. After the $5.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

Effective 09/29/02

Providers are subject to the Department's copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

96.09 **BILLING INSTRUCTIONS**

A. Billing must be accomplished in accordance with the Department's billing requirements found in the "Billing Instructions for Home Health Agencies".

Effective 09/29/02

B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, General Administrative Policies and Procedures.

Effective 09/29/02

C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86

96.09 **BILLING INSTRUCTIONS** (cont.)

Effective 09/29/02 D. Billing for all PDN/PCS delivered to individuals age 21 and over, excluding members whose level of care is Level VI or Level VII shall be submitted to the Home Care Coordinating Agency for reimbursement. The HCCA shall only reimburse services provided according to the ASA's authorized plan of care.

Effective 09/29/02 Billing for services delivered to children under age 21 for all venipuncture services, and for all medication services, shall be submitted to the Department.

Appendix #1
TASK TIME ALLOWANCES

ADL = Activities of Daily Living

Activity	Definitions	Time Estimates		Considerations
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes		Positioning supports, cognition, pain, disability level
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes up to 15 minutes		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition Mechanical lift transfer
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done in POC)		Disability level, type of aids used, cognition, pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes		Supervision, disability, cognition, pain, type of clothing, type of prosthesis
Eating	How person eats and drinks (regardless of skill)	5 minutes 30 minutes 30 minutes		Set up, cut food and place utensils Individual is fed Supervision of activity due to swallowing, chewing, cognition issues
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 -15 minutes/use		Bowel, bladder program, ostomy regimen, catheter regimen, cognition
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	Washing face, hands, perineum, combing hair, shaving and brushing teeth	20 min/day	Disability level, pain, cognition, adaptive equipment.
		Shampoo (only if done separately)	15 min up to 3 times/week	
		Nail Care	20 min/week	
Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assistance needed.		Disability, cognition, pain, mode of ambulation (cane), prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes		If shower used and shampoo done then consider as part of activity, cognition

Appendix #1
TASK TIME ALLOWANCES

IADL = Instrumental Activities of Daily Living

Activity	Definitions	Time Estimates	Considerations
Light Meal, Lunch & Snacks	Preparation and clean up	5 – 20 minutes	Consumer participation; type of food preparation; number of meals in POC and preparation for more than one meal
Main Meal Preparation	Preparation and clean up of main meal	20 - 40 minutes	Is Meals on Wheels being used? Preparation time for more than one meal and consumer participation
Light Housework/ Routine Housework	Dusting, picking up living space Kitchen housework- put the groceries away, general cleaning Making/changing beds Total floor care all rooms and bathrooms Garbage/trash disposal Non-routine tasks, outside chores, seasonal	30 min – 1.5 hr/week	Size of environment, consumer needs and participation, others in household
Grocery Shopping	Preparation of list and purchasing of goods	45 min - 2 hours/week	Other errands included: bills, banking and pharmacy. Distance from home
Laundry	Sort laundry, wash, dry, fold and put away	In-home 30 minutes/load 2 loads/week	Other activities which can be done if laundry is done in the house or apartment
		Out of home 2 hours/week	

- Task time allowances are used for the authorization of covered services under this Section. Refer to Section 96.04(C).

  These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Agent and PDN provider will use these allowances when authorizing a consumer's care plan. If these times are not sufficient when considered in light of a consumer's extraordinary circumstances as identified by the Authorized Agent, the Authorized Agent may make an appropriate adjustment.